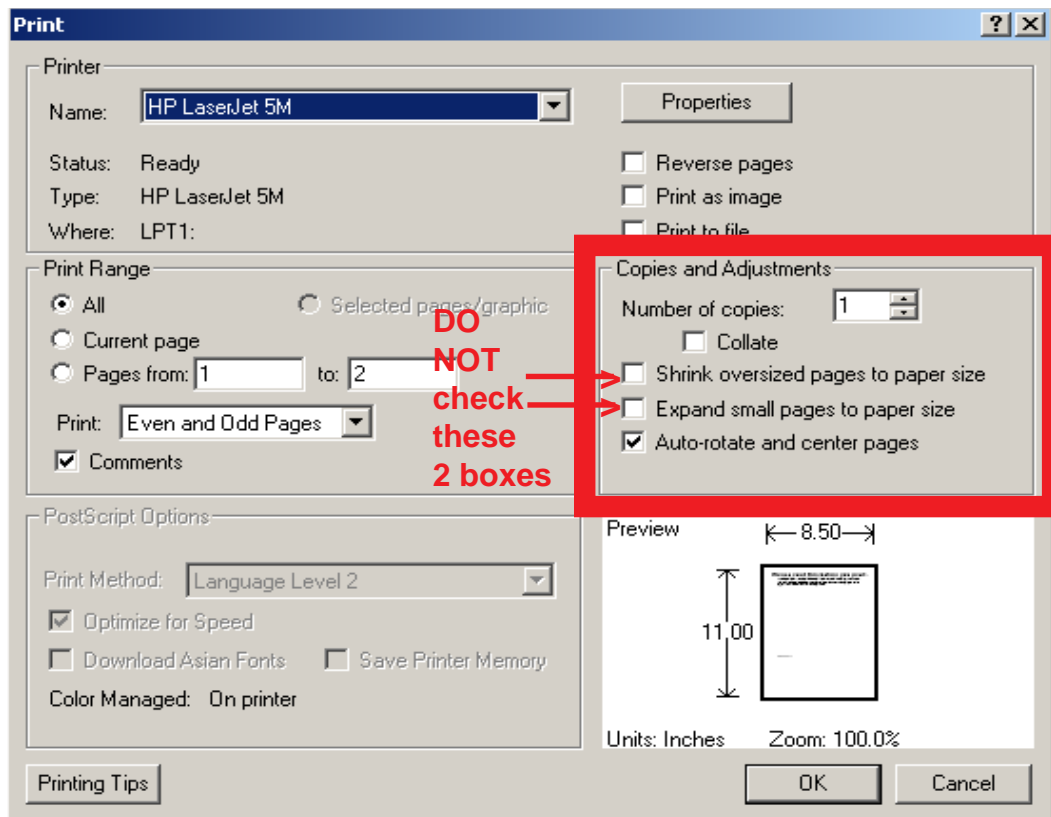


Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



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Washington State Department of

Health

Health Professions Quality Assurance Division

P.O. Box 1099

Olympia, WA 98507-1099

A. Contents:

Licensed Practical Nurse (Foreign Training) Activation Packet

1. 669-228 ... Contents List/SSN Information/Deposit Slip 1 page
2. 669-232 ... Licensed Practical Nurses Educated Outside the United States, NCLEX,
HIV/AIDS Information 2 pages
3. 669-002 ... Application for License Activation by Examination or Endorsement 4 pages
5. 669-235 ... Statement of Eligibility 2 pages

B. Important Social Security Number Information:

- * Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
- * Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099.**



Cut along this line and return the form below with your completed application and fees.



Licensed Practical Nurse

DEPOSIT SLIP

NAME (Please Print)

Revenue Section

P.O. Box 1099

Olympia, Washington 98507-1099

DATE
Please note amount enclosed, and return
with your application.

\$

☐ ☐
Check

Money Order

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Washington State Department of
Health
Washington State Nursing Commission
P.O. Box 1099
Olympia, WA 98507-1099

Licensed Practical Nurses Educated Outside The United States

Please Read This And Your NCLEX Candidate Bulletin

Persons whose nursing education was **not** in English must complete the TOEFL exam prior to applying for the National LPN exam in Washington State.

TOEFL—PO Box 6151—Princeton, NJ 08541-6151 (609) 771-7100

Instructions:

The following information is needed in our office before you will be eligible to take the LPN exam:

1. Application and \$65 fee (this fee is non-refundable)
2. One 2-inch by 2-inch recent picture of yourself.
3. Transcripts directly from your school of nursing or another board of nursing.
4. Copy of 7 hours of HIV/AIDS education certificate of completion.
5. TOEFL certificate or a letter stating your nursing program was in English.

Mail the 5 items listed above to:

Washington Nursing Commission
PO Box 1099
Olympia WA 98507-1099

NCLEX-PN Candidate Bulletin:

Please carefully read and follow the directions in your Candidate Bulletin. You must mail your exam registration form, with the fee, in the enclosed, pre-addressed envelope. Mail this registration form (to the testing company) at the same time you mail your application for licensure by exam to the Washington Nursing Commission. **Do Not Throw** your Candidate Bulletin away until after you receive your test results. The Candidate Bulletin will tell you how to complete and file the registration form with the testing company and answer many of your questions.

Your ATT (authorization to test) comes from the testing company (ETS) not the Nursing Commission. The ATT will advise you on how to schedule yourself for the exam. Allow a minimum of four (4) weeks from the time you mail your application and registration before calling for information.

Results: We receive the test results approximately 10 days after you test. We then process them and mail these results (with a license if you pass) within 3 weeks of your test date. There are hundreds of test-takers every week. Please allow 4 weeks from the time you test until you receive your results in the mail.

Download the NCLEX Examination Candidate Bulletin from their website at www.ncsbn.org.

Should you fail the NCLEX-PN, you will be sent information on retesting. You have the opportunity to test 4 times in a two-year period of time.

(360) 236-4706 for questions.

Important Information—Please Read

All applicants for LPN licensure in Washington State are required to complete an approved LPN program.

If you are a graduate of a foreign RN nursing program, you need to have taken a socialization course for licensed practical nurses. This course is referred to as “Personal and Vocational Relationships of the Practical Nurse.”

You should contact your local community college and inquire about taking this course. Once you have completed the above course, please have the Nursing School mail verification directly to our office.

If you have any questions regarding this request or the licensing process, please contact our office at the address on your instructions.

HIV/AIDS Information

AIDS Education Requirements for Health Related Professions

All health related professions under the disciplinary authority of the Uniform Disciplinary Act (RCW 18.130) are affected. This requirement went into effect January, 1989.

The topics that must be covered by this requirement are: *etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality and psychosocial issues to include special population considerations*. The course must be seven (7) hours or more in length.

If you completed your nursing program in 1989 or later and completed this requirement in the nursing courses, or a CE course, etc., after this time, you may complete the attestation portion of your application which specifies you have met this requirement. Keep documentation of completion for future reference. You may need to show proof to an employer.

If you feel you have not met this requirement, or you cannot document that you have, you can meet this requirement through a correspondence course or a community college. A partial listing of available offerings follows:

Robert D. Anderson Publishing Company

1-800-532-2332

Intercollegiate Center for Nursing Education

(509) 324-7356

University of Washington

(206)543-1047

Impact Inc.

(206) 284-3865

Department of Health

AIDS Information Hot Line

1-800-272-2437

Website: www.doh.wa.gov/cfh/hiv.htm Select “prevention”

New York State Nurses Association

(518) 782-9400

E-mail: info@nysna.org

Website: <http://www.nysna.org>



Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099

| FOR OFFICE USE ONLY | | |
|--|------------------|-------------------|
| LICENSE DATE | CANDIDATE NUMBER | VALIDATION NUMBER |
| SCHOOL CODE | GRADUATE DATE | |
| <input type="checkbox"/> AIDS <input type="checkbox"/> Cert <input type="checkbox"/> MBOS <input type="checkbox"/> Verif (Foreign) <input type="checkbox"/> Photo <input type="checkbox"/> Scripts <input type="checkbox"/> CGFNS <input type="checkbox"/> TOEFL <input type="checkbox"/> Active License <input type="checkbox"/> Other | | |

LICENSE #

Application For License By Examination Or Endorsement

☐ **Registered Nurse**

☐ Examination ☐ Endorsement

☐ **Licensed Practical Nurse**

☐ Examination ☐ Endorsement

Please Type or Print Clearly—Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application. All applications must be accompanied by applicable fee which is non-refundable. Photo copied applications are not accepted. Make remittance payable to the Department of Health.

1. Demographic Information

| | | | | |
|---|------------------------|------------------------------|--|----------------|
| APPLICANT'S NAME | | LAST | FIRST | MIDDLE INITIAL |
| MAILING ADDRESS | | | | |
| CITY | | STATE | ZIP | COUNTY |
| TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.) () | | RESIDENCE TELEPHONE () | SOCIAL SECURITY NUMBER (Required for license under 42 USC 666 and Chapter 2.23 RCW) — — | |
| GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female | BIRTHDATE (MO/DATE/YR) | PLACE OF BIRTH | | |

Have you ever been known under any other name(s)? ☐ Yes ☐ No

If yes, list

2. Education

High school graduate? ☐ Yes ☐ No

If no, GED? ☐ Yes ☐ No

Attach Current Photograph Here.
Indicate Date Taken and Sign in Ink Across Bottom of the Photo.
Required for examination only, not endorsement applicants.

NOTE: Photograph **Must** Be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view—not profile
5. Instant Polaroid Photographs **are NOT** acceptable

| INSTITUTION | NAME | LOCATION | DATE ENTERED | DATE COMPLETED | DIP/DEGREE GRANTED |
|-----------------------|------|----------|--------------|----------------|--------------------|
| COLLEGE OR UNIVERSITY | | | | | |
| COLLEGE OR UNIVERSITY | | | | | |
| COLLEGE OR UNIVERSITY | | | | | |
| COLLEGE OR UNIVERSITY | | | | | |

3. AIDS Education and Training Attestation

I certify I have completed the minimum of seven (7) hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

| | |
|----------------------|------|
| APPLICANT'S INITIALS | DATE |
|----------------------|------|

4. Personal Data Questions

YES NO

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

(If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:

a. the use or distribution of controlled substances or legend drugs? ☐ ☐

b. a charge of a sex offense? ☐ ☐

c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving) ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceedings to have:

a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? ☐ ☐

b. committed any act involving moral turpitude, dishonesty or corruption? ☐ ☐

c. violated any state or federal law or rule regulating the practice of a health care professional? ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements. ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority? ☐ ☐

9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession? ☐ ☐

5. Previous Licensure

List all states where any health care licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current.

| STATE/JURISDICTION | PROFESSION | LICENSE TYPE | LICENSE | | METHOD OF LICENSURE |
|--------------------|------------|--------------|-------------|--------|---------------------|
| | | | YEAR ISSUED | NUMBER | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

6. Licensure In Other State(s) Or Country(ies)

List all states/countries you have held an RN or an LPN license in. List these licenses in the order they were issued to you (1st, 2nd, 3rd, etc.)

| STATE/COUNTRY | CHECK ONE | | CURRENT EXPIRATION DATE |
|---------------|-----------|--------|-------------------------|
| | AS RN | AS LPN | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

State or country in which originally licensed by examination. _____

Year license first issued _____ as an ☐ RN ☐ LPN

Have you taken the State Board Test Pool Examination (SBTPE) or NCLEX in the United States? ☐ Yes ☐ No

If yes, state _____ as an ☐ RN ☐ LPN

Have you ever applied for licensure in Washington prior to this application? ☐ Yes ☐ No

If yes, under the name of _____ as an ☐ RN ☐ LPN Approximate date _____

7. Applicant's Attestation

I, _____, certify that I am the person described and identified in
NAME OF APPLICANT

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

SIGNATURE OF APPLICANT

DATE

Official Use Only

Washington State Records Center

Statement Of Eligibility

| | |
|---|--|
| FULL NAME (LAST, FIRST, MIDDLE, MAIDEN) | |
| ADDRESS (STREET, CITY, STATE, ZIP) | |
| BIRTHDATE (MONTH, DAY, YEAR) | |

This form is to be completed on both sides by the Director/Coordinator of the nursing program. Return directly to the Nursing Commission (address above) **along with an official copy of the applicant's transcript.**

1. I certify that _____ is currently/was enrolled in the accredited nursing program at _____ located in _____ ; and that the above is/was at time of departure in good standing. ☐ Yes ☐ No (If "No," please explain fully on the bottom of this form.)

2. Admission date _____ Graduation date (if applicable) _____

The above named has completed _____ Quarters _____ Semesters _____ Units _____ Nursing Credits in the nursing program (fill in whatever blanks apply to your program), which includes the subject matter as stated on form.

Please send an Official Copy of the Transcripts. NOTE: Both sides must be completed and signed by the Director/Coordinator.

SCHOOL SEAL

NAME

TITLE

DATE

Please send form and transcripts to: Department of Health
Nursing Commission
P.O. Box 47864
Olympia, WA 98504-7864

Please respond to each item listed

Subject Matter

| | Completed | Not Completed |
|--|--------------------------|--------------------------|
| 1. Social, behavioral and related foundation subjects | | |
| a. Personal and Vocational Relationships of the Practical Nurse | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Normal Growth and Development Through the Life Cycle | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Psychology—Social Facts and Principles (May be integrated into nursing courses) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Biological and related foundation subjects | | |
| a. Anatomy and Physiology | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Elementary Concepts—Microbiology, Chemistry and Physics (check completed box if integrated into fundamentals or other courses) | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Nutrition and Diet Therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Pharmacology and Applied Mathematics | <input type="checkbox"/> | <input type="checkbox"/> |

Clinical Experience

| | Completed | Not Completed |
|--|--------------------------|--------------------------|
| 3. Principles and practice of practical nursing | | |
| a. Fundamentals of nursing | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Clinical pharmacology | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Medical/surgical nursing | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Obstetrics (pre and post partum care and care of infants) | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Pediatric nursing (well and ill child) | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Geriatric nursing | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Mental health nursing (objectives can be met in ANY clinical area) | <input type="checkbox"/> | <input type="checkbox"/> |